**Date:** [**Date Notice is Mailed**]

To ask for a health plan appeal, you can call Driscoll Health Plan at: 1-877-324-7543, email: DHP\_QM\_Appeals@dchstx.org, or you can fill out this form and mail or fax it to us.

Driscoll Health Plan

Quality Management Department

Attn: Member Appeals Team

4525 Ayers Street

Corpus Christi, Texas 78415

Fax Number: 361-808-2186

**You must request an appeal by: [date 60 days from the date notices is mailed]**

If you want to continue your services during your appeal, you must make your request by: **[date must be the later of the following: 10 days from the date this notice is mailed, or the date services will change]**

**Mark the appeal you want:** *(Only select one)*

 Health Plan Appeal

 Emergency Health Plan Appeal\*

*\*Emergency health plan appeals should only be requested if you believe your health will be seriously harmed by waiting for your health plan appeal decision.*

**Authorization Reference Number: [Number]**

**Do you want your services to continue?**  \_\_\_\_Yes \_\_\_\_No

You must request your services to continue by: **[date must be the later of the following: 10 days from the date this notice is mailed, or the date services will change]**

You can make this request by phone. Call Driscoll Health Plan at 1-877-324-7543 if you think this form will not reach us by mail before the deadline.

**Your Personal Information\***

|  |  |
| --- | --- |
| **Member Name:** | **Parent or legal authorized representative:**  |
| **Member Medicaid ID:** | **Preferred Phone Number**  |

*\*If any of your information has changed, call the enrollment broker at 1-800-964-2777* ***OR***

*Driscoll Health Plan at 1-877-324-7543*

**Your Authorized Representative’s or Parent’s Information**

You can represent yourself. If you would like someone to represent you such as a parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

**Relationship to the Member:** *(Please check one)*

( ) Legally Authorized Representative ( ) Family Member ( ) Friend ( ) Provider ( ) Attorney ( ) Provider of Record

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | **Phone:** |  |
| **Address:** |  | **City:** |  |
| **State:** |  | **Zip Code:** |  |

**Provider Information**

*Provide information about the doctor or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member:*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Phone:** |  |
| **Address:** |  | **City:** |  |
| **State:** |  | **Zip Code:** |  | **Fax:** |  |

**Reason for Appeal**

This section is optional. You can fill it out to tell us about your services under appeal and why you think they’re needed.

|  |
| --- |
| **Services Under Appeal:** |
| **Why you need them:** |

**Sign this Form:** By signing this form, you or your authorized representative are requesting an appeal and giving your health plan, Driscoll Health Plan, authorization to obtain your medical records and to contact your appeal representative, if you listed one.

|  |
| --- |
|  |
| **Member/Authorized Representative**  |
|  |  |  |
| **Printed Name** |  | **Date:** |